EDMUND G. BROWN JR., Attorney General
of the State of California
WILBERT E. BENNETT
Supervising Deputy Attorney General
DIANN SOKOLOFF, State Bar No. 161082
Deputy Attorney General
1515 Clay Street, 20th Floor
P.O. Box 70550
Oakland, CA 94612-0550
Telephone: (510) 622-2212
Facsimile: (510) 622-2270

Attorneys for Complainant

BEFORE THE
BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: ROSE ANN MCKENZIE 1423 Mississauga Valley Blvd., #210 Mississauga, Ontario, Canada L5A4A5 Registered Nurse License No. 582112 Respondent.	Case No. 2008-274 OAH No. **DEFAULT DECISION AND ORDER** [Gov. Code, §11520]

FINDINGS OF FACT

1. On or about April 1, 2008, Complainant Ruth Ann Terry, M.P.H., R.N., in her official capacity as the Executive Officer of the Board of Registered Nursing, Department of Consumer Affairs, filed Accusation No. 2008-274 against Rose Ann McKenzie (Respondent) before the Board of Registered Nursing.

2. On or about June 19, 2001, the Board of Registered Nursing (Board) issued Registered Nurse License No. 582112 to Respondent. The Registered Nurse License expired on January 31, 2003, and has not been renewed.

3. On or about April 15, 2008, Shontane McElroy, an employee of the Department of Justice, served by Certified and First Class Mail a copy of Accusation No. 2008-274, Statement to Respondent, Notice of Defense, Request for Discovery, and Government Code sections 11507.5, 11507.6, and 11507.7 to Respondent's address of record with the Board, which was and is:

Rose Ann McKenzie
1423 Mississauga Valley Blvd., #210
Mississauga, Ontario, Canada L5A4A5.

A copy of the Accusation is attached as Exhibit A, and is incorporated herein by reference.

4. Service of the Accusation was effective as a matter of law under the provisions of Government Code section 11505, subdivision (c).

5. On or about May 8, 2008, the documents were returned by the U.S. Postal Service marked "Moved Unknown."

6. Business and Professions Code section 118 states, in pertinent part:

"(b) The suspension, expiration, or forfeiture by operation of law of a license issued by a board in the department, or its suspension, forfeiture, or cancellation by order of the board or by order of a court of law, or its surrender without the written consent of the board, shall not, during any period in which it may be renewed, restored, reissued, or reinstated, deprive the board of its authority to institute or continue a disciplinary proceeding against the licensee upon any ground provided by law or to enter an order suspending or revoking the license or otherwise taking disciplinary action against the license on any such ground."

7. Government Code section 11506 states, in pertinent part:

"(c) The respondent shall be entitled to a hearing on the merits if the respondent files a notice of defense, and the notice shall be deemed a specific denial of all parts of the accusation not expressly admitted. Failure to file a notice of defense shall constitute a waiver of respondent's right to a hearing, but the agency in its discretion may nevertheless grant a hearing."

8. Respondent failed to file a Notice of Defense within 15 days after service upon her of the Accusation, and therefore waived her right to a hearing on the merits of Accusation No. 2006-247.

9. California Government Code section 11520 states, in pertinent part:

> (a) If the respondent either fails to file a notice of defense or to appear at the hearing, the agency may take action based upon the respondent's express admissions or upon other evidence and affidavits may be used as evidence without any notice to respondent.

10. Pursuant to its authority under Government Code section 11520, the Board

finds Respondent is in default. The Board will take action without further hearing and, based on the evidence on file herein, finds that the allegations in Accusation No. 2008-274 are true.

11. The total cost for investigation and enforcement in connection with the Accusation are $9,547.25 as of May 15, 2008.

DETERMINATION OF ISSUES

1. Based on the foregoing findings of fact, Respondent Rose Ann McKenzie has subjected her Registered Nurse License No. 582112 to discipline.

2. A copy of the Accusation is attached.

3. The agency has jurisdiction to adjudicate this case by default.

4. The Board of Registered Nursing is authorized to revoke Respondent's Registered Nurse License based upon the following violations alleged in the Accusation:

A. Business and Professions Code section 2761(a)(1) (Gross Negligence) in that respondent engaged in gross negligence in carrying out usual nursing functions while employed as a registered nurse (traveling nurse) at the University of California at San Francisco Medical Center (UCSF).

ORDER

IT IS SO ORDERED that Registered Nurse License No. 582112, heretofore issued to Respondent Rose Ann McKenzie, is revoked.

Pursuant to Government Code section 11520, subdivision (c), Respondent may serve a written motion requesting that the Decision be vacated and stating the grounds relied on within seven (7) days after service of the Decision on Respondent. The agency in its discretion may vacate the Decision and grant a hearing on a showing of good cause, as defined in the statute.

This Decision shall become effective on September 15, 2008.

It is so ORDERED August 15, 2008

LaFrancine M Tate

FOR THE BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS

Exhibit A

Accusation No. 2008-276

EDMUND G. BROWN, Attorney General
of the State of California
DIANN SOKOLOFF, State Bar No. 161082
Deputy Attorney General
California Department of Justice
1515 Clay Street, 20th Floor
P.O. Box 70550
Oakland, CA 94612-0550
Telephone: (510) 622-2212
Facsimile: (510) 622-2270

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BEFORE THE
BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: ROSE ANN MCKENZIE 1423 Mississauga Valley Blvd, #210 Mississauga, Ontario, Canada L5A4A5 Registered Nurse License No. 582112 Respondent.	Case No. 2008-274 **A C C U S A T I O N**

Complainant alleges:

PARTIES

1. Ruth Ann Terry, M.P.H., R.N. (Complainant) brings this Accusation solely in her official capacity as the Executive Officer of the Board of Registered Nursing, Department of Consumer Affairs.

2. On or about June 19, 2001, the Board of Registered Nursing issued Registered Nurse License Number 582112 to ROSE ANN MCKENZIE (Respondent). The Registered Nurse License was in full force and effect at all times relevant to the charges brought herein and expired on January 31, 2003. It is currently in delinquent status.

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JURISDICTION

3. This Accusation is brought before the Board of Registered Nursing (Board), Department of Consumer Affairs, under the authority of the following laws. All section references are to the Business and Professions Code unless otherwise indicated.

STATUTORY PROVISIONS

4. Section 2750 of the Business and Professions Code (Code) provides, in pertinent part, that the Board may discipline any licensee, including a licensee holding a temporary or an inactive license, for any reason provided in Article 3 (commencing with section 2750) of the Nursing Practice Act.

5. Section 2764 of the Code provides, in pertinent part, that the expiration of a license shall not deprive the Board of jurisdiction to proceed with a disciplinary proceeding against the licensee or to render a decision imposing discipline on the license. Under section 2811(b) of the Code, the Board may renew an expired license at any time within eight years after the expiration.

6. Section 2761 of the Code states:

"The board may take disciplinary action against a certified or licensed nurse or deny an application for a certificate or license for any of the following:

"(a) Unprofessional conduct, which includes, but is not limited to, the following:

"(1) Incompetence, or gross negligence in carrying out usual certified or licensed nursing functions."

7. Title 16, California Code of Regulations, section 1442, states:

"As used in Section 2761 of the code, 'gross negligence' includes an extreme departure from the standard of care which, under similar circumstances, would have ordinarily been exercised by a competent registered nurse. Such an extreme departure means the repeated failure to provide nursing care as required or failure to provide care or to exercise ordinary precaution in a single situation which the nurse knew, or should have known, could have jeopardized the client's health or life."

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8. Section 125.3 of the Code provides, in pertinent part, that the Board may request the administrative law judge to direct a licentiate found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case.

CAUSE FOR DISCIPLINE

(Gross Negligence)

9. Respondent is subject to disciplinary action under Code section 2761(a)(1) in that she engaged in gross negligence in carrying out usual nursing functions while employed as a registered nurse (traveling nurse) at the University of California at San Francisco Medical Center (UCSF). During this employment, respondent provided nursing care in a grossly negligent manner by failing to appropriately monitor a post-surgical patient, S.S., on December 26 and 27, 2001. (Respondent was identified as S.S.'s nurse from December 26, 2001 at 8:00 p.m., to December 27, 2001, at 7:30 a.m.) The circumstances are as follows:

PATIENT S.S.

a. S.S. was a 41 year old male who had a chronic history of head, neck and low back pain. On December 26, 2001, S.S. had elective surgery under anesthesia to treat his cervical disc decompression of C3-C4 and to release pressure and chronic pain from his spinal cord canal at UCSF. The surgery was without complication.

b. After the surgery, anesthesia was reversed and S.S. was sent to the Post Anesthesia Care Unit (PACU) in stable condition at 6:20 p.m. on December 26, 2001. The post-operative neurological exam showed no new motor or sensory deficits. After the operation, S.S. had severe pain requiring high doses of opiates and benzodiazepine. His pain was managed with a total of 20 mg of I.V. Morphine Sulfate, 50 mg of I.V. Demerol and 0.5 mg of I..V. Ativan. In addition, a Morphine Sulfate PCA (Patient Controlled Anesthesia) pump was also started in the PACU.

c. Respondent's first contact with S.S. occurred at 8:00 p.m. on December 26, 2001, when S.S. was transferred from the PACU to 8L, a medical/surgical floor where Respondent received him.

d. At 8:00 p.m., Respondent conducted the initial screening assessment and at 9:00 p.m. she conducted the neurological assessment.

e. The PCA Narcotic Orders, which Respondent checked at 8:00 p.m. when she received S.S. into 8L, required that S.S.'s respiratory rate, pain scale, sedation level and total amount of Morphine Sulfate infused be monitored and the results be documented every two hours for eight hours and then every four hours. But Respondent failed to follow those orders, and, instead, monitored and documented these items at 8:30 p.m. (December 26), 12:00 a.m. (December 27), and 5:00 a.m. (December 27). Respondent charted on the Spinal Cord Testing Record at 8:00 p.m. and 12:00 a.m. (December 27) that S.S. was a 5 on his right and left sides. Respondent charted on S.S.'s Neurological Assessment Record at 8:00 p.m., 12:00 a.m. (December 27) and 4:00 a.m. (December 27).

f. At 6:00 a.m., on December 27, 2001, S.S. was found to be hypoventilating and unresponsive. Narcan was administered but S.S. remained unresponsive. S.S. was transferred to the Intensive Care Unit with a diagnosis of acute respiratory failure and shock. On March 27, 2002, S.S. was discharged from UCSF and transferred to St. Jude Hospital as a quadriplegic, with brain damage, requiring lifelong care.

g. The community standard is that a nurse should monitor post-operative vital signs such as heart rate, respiratory rate, blood pressure including oxygen saturation, when a patient arrives on the floor, 15 minutes later, then every thirty minutes for two hours, then one hour later, and then every four hours, or more frequently if ordered. Respondent took S.S.'s vital signs at 8:00 p.m., 10:00 p.m., 2:00 a.m. (December 27), and 6:00 a.m. (December 27).

h. According to the Neurosurgery Orders, on December 26, 2001, at 5:00 p.m., S.S.'s neurosurgical team of doctors ordered the following medications: Percocet, Ziagen, Zerit, Sustive, Valium, Acetaminophen, Diphenhydramine, Droperidol, Colace, Ambien and Neurontin.

i. According to the PAC Narcotic Orders, on December 26, 2001, at 5:00 p.m., S.S.'s pain service team of doctors ordered the following medications for S.S.: Morphine, Diphenendydramine, Droperidol, Lorazepam, and Naloxone (Narcan). These orders stated "no

IV (intravenous), PO (by mouth), IM (intramuscular) or SQ (subcutaneous) narcotics are to be given unless ordered by the physician/service below."

j. According to the PACU Admission/Discharge Orders, S.S.'s doctor ordered Demerol for him.

k. S.S. received the following medications in the PACU: total of 20 mg. of Morphine Sulfate IV, Demerol 50 mg IV, Ativan 0.5 mg, and the PCA pump was started with a dose of 3 mg of Morphine Sulfate with a six minute delay and a one-hour limit of 35 mg.

l. Respondent administered the following medications in accordance with the Neurosurgery orders: Morphine Sulfate 5 mg (8:30 p.m.), Percocet 2 tablets, Valium 5 mg, Neurontin 200 mg (9:00 p.m.), Ambien 10 mg (10:00 p.m.), Tylenol 650 mg. (11:00 p.m.) and Morphine Sulfate 5 mg and Ativan 1 mg. (12:00 a.m.). Administering some of these medications violated the PCA order restrictions.

m. In providing nursing care to S.S., Respondent made several documentation/assessement errors in failing to properly monitor the patient in the following respects:

(1) She failed to properly monitor this patient by not following the doctor's orders from the pain management service team.

(2) She failed to get clarification about the two sets of medication orders: one from the neurosurgery team and one from the pain management service team, thereby creating a risk that the cumulative effect of the various medications would cause respiratory arrest.

(3) She failed to document and reassess the patient's heart rate, respiratory rate, blood pressure, oxygen saturation, pain scale, sedation level, and total amount of morphine sulfate infused by the PCA pump every two hours for eight hours and then every four hours, as ordered by S.S.'s pain management service team.

(4) As a result of respondent's documentation and assessment errors, the patient was placed at risk for a significant deterioration in respiratory status leading to his respiratory arrest.

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PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Board of Registered Nursing issue a decision:

1. Revoking or suspending Registered Nurse License Number 582112, issued to ROSE ANN MCKENZIE;

2. Ordering ROSE ANN MCKENZIE to pay the Board of Registered Nursing the reasonable costs of the investigation and enforcement of this case, pursuant to Business and Professions Code section 125.3;

3. Taking such other and further action as deemed necessary and proper.

DATED: 4/11/08

RUTH ANN TERRY, M.P.H., R.N.
Executive Officer
Board of Registered Nursing
Department of Consumer Affairs
State of California
Complainant

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